5101:3-3-521 Exception review process for nursing facilities (NFS).

(A) Definitions: The terms used in this rule have the same meaning as in rule 5101:3-3-40 of the Administrative Code, or are defined below:

(1) "Exception review" is a review conducted at selected nursing facilities (NFs) by appropriate health professionals employed by the Ohio department of human services (ODHS), for purposes of identifying any patterns or trends related to resident assessments submitted in accordance with rule 5101:3-3-40 of the Administrative Code, which could result in inaccurate case mix scores used to calculate the direct care rate.

(2) "Effective date of the rate" is the first day of the payment quarter.

(3) "Exception review tolerance level" is the level of variance between the facility and ODHS in ~~MDS+~~ MDS 2.0 assessment item responses affecting the ~~RUG-III~~ RUG III classification of a facility's residents . Two kinds of tolerance levels have been established for exception reviews: initial sample, and expanded review.

(a) "Initial sample tolerance level" is the percentage of unverifiable records found in the initial sample of resident records during the first phase of an exception review, below which no further review will be pursued. The exception review tolerance level for the initial sample of reviewed records from the most recent reporting quarter shall be either fifteen per cent of the entire sample, or fifteen per cent of the number of residents in the sample grouped in any major category of resident types, as set forth in paragraph (B) of rule 5101:3-3-41 of the Administrative Code., EXCEPT THAT:

THE INITIAL SAMPLE TOLERANCE LEVEL WILL NOT BE CALCULATED SOLELY ON THE BASIS OF A MAJOR CATEGORY OF RESIDENT TYPES IF THE TOTAL NUMBER OF REVIEWED RECORDS IS LESS THAN THE MINIMUM SAMPLE SIZE SPECIFIED IN APPENDIX A OF THIS RULE.

(b) "Expanded review tolerance level" is an acceptable level of variance in the calculation of a NF's quarterly facility average case mix score OR AN ACCEPTABLE PER CENT OF THE RECORDS USED FOR RATE SETTING THAT WERE UNVERIFIABLE. The CASE MIX SCORE variance is calculated as a percentage difference between the score based on exception review findings compared to the score based on the NF's submitted assessment records for that quarter.

(i) For an exception review of the most recent reporting quarter conducted before the effective date of the rate, the exception review tolerance level shall be EITHER a two per cent difference between the quarterly facility average case mix score based on exception review findings and the quarterly facility average case mix score from the NF's submitted ~~MDS+~~ MDS2.0 records OR TWENTY PER CENT OF THE RECORDS USED FOR RATE SETTING WERE UNVERIFIABLE.

(ii) For an exception review of a given reporting quarter conducted after the effective date of the rate, the exception review tolerance level shall be EITHER a three per cent difference between the quarterly facility average case mix score based on exception review findings and the quarterly facility average case mix score from the NF's submitted ~~MDS+~~ MDS2.0 records OR TWENTY PER CENT OF THE RECORDS USED FOR RATE SETTING WERE UNVERIFIABLE.

(4) A "~~Verified MDS+~~ VERIFIABLE MDS2.0 record" is a NF's completed ~~MDS+~~ MDS2.0 assessment form, based on facility-supplied ~~MDS+~~ MDS2.0 assessment data, submitted to ~~ODHS~~ THE STATE for a resident for a specific reporting quarter, which upon examination by ODHS, has been determined to accurately represent the aspects of the resident's condition, during the specified assessment time frame, that affect the correct classification of that record into the ~~resource utilization groups, version III (RUG-III)~~ (RUG III) case mix payment system. Verification activities include reviewing resident assessment forms and supporting documentation, conducting interviews, and observing residents. An "~~unverified MDS+~~ UNVERIFIABLE MDS2.0 record" is one which, upon examination, has been determined to ~~not accurately represent the resident's condition, and therefore may~~ result in the resident's inaccurate classification into the ~~RUG-III~~ RUG III system.

(B) All exception reviews will comply with the applicable rules prescribed pursuant to ~~titles~~ TITLE XVIII and TITLE XIX of the Social Security Act.

(C) NFs may be selected for an exception review by ODHS based on any of the following:

(1) The findings of a certification survey conducted by the Ohio department of health that may indicate that the facility is not accurately assessing residents, which may result in the resident's inaccurate classification into the ~~RUG-III~~ RUG III system;

(2) A risk analysis profile of NFs with a sudden or drastic change in the frequency distribution of their residents in the major ~~RUG-III~~ RUG III categories or a sudden or drastic change in the facility average case mix score; or NFs for which ~~other data indicate~~ INFORMATION INDICATES that the assessment ~~information~~ RECORD submitted by the facility may not result in accurate classification of the facility's residents in the ~~RUG-III~~ RUG III system.

(3) Prior resident assessment performance of the provider, including, but not limited to, ongoing problems with assessment submission deadlines, error rates, and incorrect assessment dates.

(D) Exception reviews shall be conducted at the facility by registered nurses and other licensed or certified health professionals under contract with or employed by ODHS. When a team of ODHS reviewers conducts an on-site exception review, the team shall be led by a registered nurse. Persons conducting exception reviews on behalf of ODHS shall meet the following conditions:

(1) During the period of their professional employment with ODHS, reviewers must neither have nor be committed to acquire any direct or indirect financial interest in the ownership, financing, or operation of a NF which they review in Ohio.

(2) Reviewers shall not review any facility that has been a client of the reviewer.

(3) Reviewers shall not review any facility that has been an employer of the reviewer.

(4) Employment of a member of a health professional's family by a NF that the professional does not review does not constitute a direct or indirect financial interest in the ownership, financing, or operation of a NF.

(E) Prior notice: ODHS shall notify the facility by telephone at least two working days prior to the review. At the time of notification, ODHS shall discuss the findings that led the department to decide to conduct an exception review. The facility may be able to satisfactorily resolve the department's concerns at this point and avert an on-site review.

(F) Scheduling/rescheduling: Exception reviews of the most recent reporting quarter may be scheduled for any

working day of the processing quarter, including the time between that reporting period end date and the filing date. ODHS shall notify the NF prior to the previously scheduled time if reviewers are unable to visit the NF at the arranged time. At the discretion of ODHS, the review team may reschedule the review if appropriate key personnel of the facility would be unavailable on the originally scheduled date of on-site review.

(G) Facilities selected for exception reviews must provide ODHS reviewers with reasonable access to residents, professional and nonlicensed direct care staff, the facility assessors, and completed resident assessment instruments as well as other documentation regarding the residents' care needs and treatments. Facilities must also provide ODHS with sufficient information to be able to contact the resident's attending or consulting physicians, other professionals from all disciplines who have observed, evaluated or treated the resident, such as contracted therapists, and the resident's family/significant others. These sources of information may help to validate information provided on the resident assessment instrument and submitted to ~~ODHS~~ THE STATE.

(H) An exception review shall initially be conducted of a ~~preselected~~ random, targeted, or combination sample of completed resident assessment instruments from the most recent reporting quarter. The initial sample size shall be greater than or equal to the minimum sample size presented in appendix A of this rule. THE INITIAL SAMPLE CAN BE ADJUSTED DURING THE REVIEW BASED ON PRELIMINARY FINDINGS.

(I) Results from review of the initial sample shall be used to decide if further action by ODHS is warranted. If the initial sample is to be expanded for further review, ODHS reviewers shall hold a conference with facility representatives advising them of the next steps of the review and discussing the initial sample findings. If the sample of reviewed records exceeds the initial sample tolerance level described in paragraph (A)(3)(a) of this rule, ODHS

(1) Shall first expand the sample size for the same reporting quarter and continue the review process; ~~and~~ UP TO AND INCLUDING ONE HUNDRED PER CENT OF THE RECORDS FOR THE SAME QUARTER.

(2) May subsequently expand the exception review process to review ~~MDS+~~ MDS2.0 assessments submitted for no more than two quarters previous to the most recent reporting quarter.

(J) At the conclusion of the on-site portion of the exception review process, ODHS reviewers shall hold an exit conference with facility representatives. Reviewers will share preliminary findings and/or concerns about verification or failure to verify ~~RUG-III~~ RUG III classification for reviewed records.

(K) All exception reviews shall include a written summary of findings. ODHS shall send a copy of the written summary of findings to the NF.

(L) All exception review reports shall be retained by ODHS for at least six years.

(M) If the expanded review tolerance level is exceeded, ODHS shall use the exception review findings to calculate or recalculate resident case mix scores, quarterly facility average case mix scores and annual facility average case mix scores and adjust the facility's direct care component of the rate accordingly. Calculations or recalculations shall apply only to records actually reviewed by ODHS; and shall not be based on extrapolations to unreviewed records of findings from reviewed records. For example, ODHS shall recalculate a quarterly facility average case mix score by replacing resident case mix scores of reviewed records and not changing the resident case mix scores of unreviewed records.

(N) ODHS shall use the quarterly and annual facility average case mix scores based on exception review findings which exceed the exception review tolerance level to calculate or recalculate the facility's rate for direct care costs for the appropriate calendar quarter or quarters. However, scores recalculated based on exception review findings shall not be used to override any assignment of a quarterly facility average case mix score or a facility

cost per case mix unit made in accordance with rule 5101:3-3-42 of the Administrative Code as a result of the facility's failure to submit, or submission of incomplete or inaccurate resident assessment information, unless the recalculation results in a lower quarterly facility average case mix score or cost per case mix unit than the one to be assigned.

(1) If the exception review of a specific reporting quarter is conducted before the effective date of the rate for the corresponding payment quarter, and the review results in findings that exceed the tolerance level, ODHS shall use the recalculated quarterly facility average case mix scores to calculate the facility's rate for direct care costs for that payment quarter. Calculated rates based on exception review findings may result in a rate increase or rate decrease compared to the rate based on the facility's submission of assessment information.

(2) If the exception review of a specific reporting quarter is conducted after the effective date of the rate for a corresponding payment quarter, and the review results in findings that exceed the exception review tolerance level and indicate the facility received a lower rate than it was entitled to receive, ODHS shall increase the direct care rate prospectively for the remainder of the payment quarter, beginning one month after the first day of the month after the exception review is completed.

(3) If the exception review of a specific reporting quarter is conducted after the effective date of the rate for a corresponding payment quarter, and the review results in findings that exceed the exception review tolerance level and indicate the facility received a higher rate than it was entitled to receive, ODHS shall reduce the direct care rate and apply it to the periods when the provider received the incorrect rate to determine the amount of the overpayment. Overpayments are payable in accordance with rule 5101:3-3-22 of the Administrative Code.

(O) Except for additional information submitted to ODHS as part of the processes set forth in paragraphs (P) and (Q) of this rule, the ODHS exception review determination for any resident case mix score shall be considered final and the NF may not correct or amend the ~~MDS+~~ MDS2.0 data or submit any additional information for that individual record after exception reviewers have concluded the on-site review. A NF may, however, continue to submit current changes ~~using the MDS+ correction document in accordance with rule 5101:3-3-42 of the Administrative Code~~ for individual records that were not subject to an exception review finding IN ACCORDANCE WITH RULE 5101:3-3-40 OF THE ADMINISTRATIVE CODE.

(P) The NF may seek reconsideration in accordance with paragraph (B) of rule 5101:3-3-24 of the Administrative Code for direct care rates recalculated as a result of an exception review conducted before the effective date of the rate.

(Q) The findings of an exception review conducted after the effective date of the rate may be appealed under provisions of the Administrative Procedure Act, Chapter 119 of the Revised Code. ODHS shall not withhold from the facility's current payments any amounts ODHS claims to be due from the facility as a result of the exception review finding while the NF is pursuing administrative or judicial remedies in good faith.

Appendix A

Exception Review Resident Initial Sample Selection

Resident Census on Reporting Period End Date	Minimum Initial Sample Size Required
1-4	All
5-10	5
11-20	8
21-40	10
41-44	11
45-48	12
49-52	13
53-56	14
57-75	15
76-80	16
81-85	17
86-90	18
91-95	19
96-100	20
101-105	21
106-110	22
111-115	23
116-160	24
161-166	25
167-173	26
174-180	27
181-186	28
187-193	29
194-300	30

continued: Exception Review Resident Initial Sample Selection	
Resident Census on Reporting Period End Date	Minimum Initial Sample Size Required
301-310	31
311-320	32
321-330	33
331-340	34
341-350	35
351-360	36
361-370	37
371-380	38
381-390	39
391-400	40
401-410	41
411-420	42
421-430	43
431-440	44
441-450	45
451-460	46
461-470	47
471-480	48
481-490	49
491-	50

Effective date: JUL 01 1998

Certification: [signature] JUN 19 1998

Date

Promulgated under: Chapter 119.

Statutory authority: RC Sections 5111.02, 5111.27, 5111.29.

Rule amplifies: RC Sections 5111.01, 5111.02, 5111.27, 5111.28, 5111.29.

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5101:3-3-53 ~~Rates for nursing~~ NURSING facilities (NFS); RATES FOR PROVIDERS ~~which are~~ new to the medical assistance program and ~~for NF~~ providers that change provider agreements.

(A) The Ohio department of human services (ODHS) shall determine rates for a NF which is new to the medical assistance program (a NF with a first date of licensure and subsequent certification on or after January 1, 1993, including a NF that replaces one or more existing facilities, or a NF with a first date of licensure before that date that was initially certified for the medical assistance program on or after that date) in the following manner:

(1) For the fiscal year in which the NF begins participation in the medical assistance program, the initial rate shall be set as follows:

(a) The rate for direct care costs shall be determined as follows:

(i) Except as provided in paragraph (A)(1)(a)(iv) of this rule, the initial rate shall be the cost per case mix unit (CPCMU) which reflects the median medicaid day of the peer group, multiplied by the eighteen-month inflation rate determined for the fiscal year under rule 5101:3-3-44 of the Administrative Code, multiplied by the median annual average case-mix score of the peer group. Both the CPCMU which reflects the median medicaid day of the peer group and the median annual average case-mix score of the peer group are determined from the calendar year preceding the fiscal year in which the rate will be paid. ODHS shall assign the NF to a peer group based upon the peer groups determined under rule 5101:3-3-44 of the Administrative Code.

(ii) After the NF submits quarterly assessment information for its first reporting quarter under rule 5101:3-3-40 of the Administrative Code, its rate for the following payment quarter shall be calculated using its actual case-mix score from the reporting quarter as determined under rule 5101:3-3-42 of the Administrative Code instead of the median case-mix score as prescribed by paragraph (A)(1)(a)(i) of this rule. If either of the facility's first two quarterly submissions do not contain assessment information that qualifies for use in calculating a case-mix score under rule 5101:3-3-42 of the Administrative Code, ODHS shall continue to calculate the rate using the median annual case-mix score for the peer group and shall not assign a quarterly case-mix score as provided in that rule. If any subsequent submissions do not contain assessment information that qualifies for use in calculating a case-mix score as determined under rule 5101:3-3-42 of the administrative code, ODHS ~~shall~~ MAY assign a case-mix score for the quarter that is five per cent less than the case-mix score that was used to calculate the NF's rate for the preceding calendar quarter and shall use the assigned score in place of the median case-mix score as prescribed by paragraph (A)(1)(a)(i) of this rule.

(iii) After the NF submits its three-month cost report under rule 5101:3-3-20 of the Administrative Code, its rate shall be determined using the lesser of its actual CPCMU as determined under paragraph (A)(1)(a)(iii)(a) of this rule or the maximum CPCMU FOR THE PEER GROUP from the calendar year preceding the fiscal year in which the rate will be paid ~~instead of the median CPCMU as prescribed by paragraph (A)(1)(a)(i) of this rule~~. The NF's actual CPCMU shall be used only if the NF submits assessment information that qualified for use in calculating a case-mix score under rule 5101:3-3-42 of the Administrative Code ~~for the calendar quarter that immediately preceded the immediately preceding calendar quarter. Until the facility submits assessment information that qualifies for use in calculating an actual case-mix score,~~ OTHERWISE ODHS shall continue to use the median CPCMU for the facility as prescribed by paragraph (A)(1)(a)(i) of this rule.

(a) The NF's actual CPCMU is determined by dividing the NF's desk-reviewed, actual, allowable, per diem direct care costs determined from the three-month cost report by the NF's actual case-mix score(s) from the reporting quarter or quarters that ended during the cost report period.

(b) The inflation rate used to inflate the NF's actual CPCMU referenced in paragraph (A)(1)(a)(iii) of this rule shall be determined by using the midpoint of the cost report period to the midpoint of the fiscal year in which the rate will be paid to calculate a prorated portion of the eighteen-month inflation rate determined under rule 5101:3-3-44 of the Administrative Code for that fiscal year. The inflation rate used to inflate the median CPCMU or the maximum CPCMU referenced in paragraph (A)(1)(a)(iii) of this rule shall be the eighteen-month inflation rate determined for the fiscal year under rule 5101:3-3-44 of the Administrative Code.

(iv) If the NF is a replacement facility and the facility or facilities that are being replaced are in operation immediately before the replacement NF opens, the DIRECT CARE rate shall be the same as the DIRECT CARE rate for the replaced facility or facilities, weighted by the number of beds from each replaced facility. If one or more of the replaced facilities is not in operation immediately before the replacement NF opens, its proportion of the DIRECT CARE rate shall be determined under paragraph (A)(1)(a)(i) of this rule. When the provider files its quarterly assessment information or the three-month cost report required by rule 5101:3-3-20 of the Administrative Code, the DIRECT CARE rate shall be calculated as provided in paragraphs (A)(1)(a)(ii) and (iii) of this rule.

(b) The rate for other protected costs shall be determined as follows:

(i) The initial rate shall be one hundred fifteen per cent of the median rate for all NFs as calculated at the beginning of the fiscal year in which the rate will be paid under rule 5101:3-3-49 of the Administrative Code. ONE HUNDRED FIFTEEN PER CENT OF THE MEDIAN RATE, WHICH DOES NOT INCLUDE THE FRANCHISE PERMIT FEE, WILL BE ASSIGNED FACILITIES NOT ASSESSED THIS FEE IN THEIR INITIAL RATE YEAR.

(ii) After the NF files its three-month cost report under rule 5101:3-3-20 of the Administrative Code, its rate shall be its desk-reviewed, actual, allowable per diem other protected costs determined from the three-month cost report multiplied by an inflation rate. The inflation rate used to inflate the NF's desk-reviewed, actual, allowable per diem other protected costs determined from the three-month cost report shall be determined by using the midpoint of the cost report period to the midpoint of the fiscal year in which the rate will be paid to calculate a prorated portion of the eighteen-month inflation rate determined under rule 5101:3-3-49 of the Administrative Code for that fiscal year.

(c) The rate for indirect care costs shall be determined as follows:

(i) The initial rate shall be the applicable maximum rate for the NF's peer group as calculated for the fiscal year in which the rate will be paid under rule 5101:3-3-50 of the Administrative Code. ODHS shall assign the NF to a peer group based upon the peer groups determined under rule 5101:3-3-50 of the Administrative Code.

(ii) After the NF files its three-month cost report under rule 5101:3-3-20 of the Administrative Code, the rate shall be the lesser of:

(a) The desk-reviewed, actual, allowable per diem indirect care costs from the three-month cost report multiplied by an inflation rate plus the fiscal year efficiency incentive for the NF's peer group determined under rule 5101:3-3-50 of the Administrative Code. The inflation rate ~~used to inflate the NF's desk-reviewed, actual, allowable per diem indirect care costs determined from the three-month cost report~~ shall be determined by using the midpoint of the cost report period to the midpoint of the fiscal year in which the rate will be paid to calculate a prorated portion of the eighteen-month inflation rate determined under rule 5101:3-3-50 of the Administrative Code for that fiscal year; or

(b) The maximum rate for the NF's peer group determined under rule 5101:3-3-50 of the Administrative Code for the fiscal year in which the rate will be paid.